Foster Family Home - Deficiency Report

Provider ID:	**1-200050**		
Home Name:	**Razie Tumaneng, CNA**	**Review ID:**	**1-200050-3**
91-1078 Paapaana Street		Reviewer:	Jackie Chamberlain
Ewa Beach HI 96706		Begin Date:	9/2/2021

Foster Family Home	**Required Certificate**	**[11-800-6]**

6.(d)(1) Comply with all applicable requirements in this chapter; and

Comment:

6(d)(1) CCFFH inspection made for a 2 bed re-certification.

Deficiency Report issued during CCFFH visit with corrective action plan due to CTA within 30 days of inspection.

Foster Family Home	**Personnel and Staffing**	**[11-800-41]**

41.(b)(8) Have documentation of current training in blood borne pathogen and infection control, cardiopulmonary resuscitation, and basic first aid.

41.(c) The primary caregiver shall attend twelve hours, and the substitute caregiver shall attend eight hours, of in-service training annually which shall be approved by the department as pertinent to the management and care of clients. The primary caregiver shall maintain documentation of training received by all caregivers, in the caregiver file in the home.

Comment:

41.(b)(8) No proof of current blood borne pathogen training for CG 5
41.(c) nO proof of training hours for CG # 5

Foster Family Home	**Client Care and Services**	**[11-800-43]**

43.(c)(3) Be based on the caregiver following a service plan for addressing the client's needs. The RN case manager may delegate client care and services as provided in chapter 16-89-100.

Comment:

43.(c)(3)No RN signature for delegation present for Client # 2 except for CG # 1

Foster Family Home	**Client Rights**	**[11-800-53]**

53.(b)(15) Have daily visiting hours and provisions for privacy established;

Comment:

53.(b)(15) Client # 1 does not has a lock on the inside for patient privacy

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Foster Family Home	**Records**	**[11-800-54]**

54.(b)	The home shall maintain separate notebooks for each client in a manner that ensures legibility, order, and timely signing and dating of each entry in black ink. Each client notebook shall be a permanent record and shall be kept in detail to:
54.(c)(3)	Current copies of the client's physician's orders;
54.(c)(5)	Medication schedule checklist;
54.(c)(7)	Expenditure records; and

Comment:

54.(c)(3) Client # 1 there is no signed MD orders except for a [redacted]
54.(b) white out has been used on serval medical record documents instead of approved correction of error in entry
54.(c)(7) No proof of Expenditure records for client # 1 or 2
54.(c)(5) Medication discrepancy for client # 1 and # 2 medication prescription label did not match medication administration record and / or the signed MD orders

Compliance Manager

9/2/21
Date

Primary Care Giver

9/2/21
Date